

State of Minnesota**District Court**

County

Judicial District:	
Court File Number:	
Case Type:	

☐ In Re the Marriage of:

Petitioner

and

Respondent

Intervenor

Financial Affidavit for Child Support

STATE OF MINNESOTA)
) SS
COUNTY OF _____)
(County where Affidavit Signed)

My name is _____. I am the
(check one) ☐ (Petitioner) ☐ (Respondent) in this case, and I state the following information:

1. I am the parent of _____ joint child(ren) who are the subject of this court action.
(Enter number of joint children)

2. My sources of income are:

Monthly Income Received	Amount	Monthly Income Received	Amount
Salary and Wages (before deductions)	\$	Social Security Received (social security disability, retirement, survivors' benefit)	\$
Self-Employment	\$	Child's Derivative Social Security or Veteran's Benefits	\$
Unemployment Benefits	\$	Workers' Compensation	\$
Commissions	\$	Pension, Annuity Payments, Disability Payments	\$
Spousal Maintenance Received	\$	Other source of income <i>(list source below)</i>	\$
Military and Naval Retirement	\$		
Total monthly income received:			\$

3. Proof of my income is attached to Form 11.2 and supports this Financial Affidavit.

4. Number of nonjoint children who live in my home: _____

5. Spousal Maintenance I am court ordered to pay: \$_____ per month

A copy of the court order is attached as proof.

6. Child support I am court ordered to pay for nonjoint children
and who do not live in my home: \$_____ per month

A copy of the court order is attached as proof.

7. Health care coverage information (*check one or more that apply*)

☐ I have health care coverage for the joint child(ren) in place. This ☐ does ☐ does not
include dental coverage.

The cost of monthly health care coverage for myself: \$_____ per month

The cost of monthly health care coverage for the joint child(ren): \$_____ per month

☐ I have health care coverage for the joint child(ren) available. This ☐ does ☐ does not
include dental coverage.

The cost of monthly health care coverage for myself: \$_____ per month

The cost of monthly health care coverage for the joint child(ren): \$_____ per month

☐ To my knowledge, the joint child(ren) receive(s) medical assistance / Minnesota Care.

8. Child care information (*check one*)

☐ There are child care expenses for the joint child(ren) in the amount of \$_____
per month.

☐ There are no monthly child care expenses for the joint child(ren).

☐ I am unaware of any monthly child care expenses for the joint child(ren).

9. There is a court order for parenting time with the joint child(ren) (*check yes or no*)

☐ yes ☐ no

I declare under penalty of perjury that everything I have stated in this document is true and
correct. Minn. Stat. § 358.116.

Dated: _____

Signature

Print Name: _____

Address: _____

City/State/Zip: _____

Telephone: (_____) _____

E-mail address: _____